THE RECOVERY KERNEL

How to Navigate the Recovery Kernel

For People Recovering from LSD

Lysergic acid diethylamide ("acid," "tabs," "blotter"). A step-by-step route: what to read, in what order, and what to expect. Supervised therapeutic LSD is a different context, addressed in Step 8.

> **HARM REDUCTION RESOURCE — NOT MEDICAL ADVICE. LSD does not cause physical dependence or withdrawal, and the Kernel says it has no direct overdose kill mechanism.** The dangers are a psychological emergency during a trip, unsafe behavior while impaired (traffic, heights, water), psychosis in people who are vulnerable, and adulterants: blotter sold as LSD is often something else, and NBOMe compounds can cause seizures, dangerous heart rhythms, overheating, and death at amounts that would be barely perceptible with LSD. **Call 911 for suspected NBOMe poisoning, for a person who has lost track of what is real and cannot be calmed, or for anyone in physical danger.**
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> **During a frightening trip:** move to a quiet, dim, familiar place, have one calm sober person stay, lie down, breathe slowly, and remember the effect is temporary and has a known length. Do not add caffeine or stimulants, do not go somewhere crowded, and never leave the person alone. Do not restrain aggressively. Severe panic that will not settle is a clinician's call: the Kernel names benzodiazepines as the trip-termination tool and advises against antipsychotics as a first response.
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> Crisis: call or text 988 · SAMHSA: 1-800-662-4357 · Crisis Text Line: text HOME to 741741

1. Before you start

This is a route through the Recovery Kernel for people whose relationship with LSD has become a problem, and for the friends, sitters, and clinicians around them. LSD scores extraordinarily low on every usual measure of addiction: no physical dependence, no withdrawal, no dopamine reward loop, and tolerance so fast (complete within three to four days of consecutive use) that daily use is pharmacologically impossible. The Kernel says the problems it causes are different and real: persisting visual phenomena (HPPD), an integration backlog, psychosis in vulnerable people, depersonalization, a psychological dependence on the altered state, and sometimes a meaning crisis. Its frame holds two things at once: the universe did open up, and the mechanism was the brain's prefrontal filtering being turned down so that everything seemed to carry vast significance. Six rules follow.

- **Screen for psychosis risk first.** A personal or family history of schizophrenia, schizoaffective disorder, or bipolar disorder with psychosis is an absolute contraindication, whatever the dose or setting. If LSD has triggered psychosis, psychiatric care is the primary track.
- **Know HPPD from psychosis.** HPPD is usually benign and time-limited, and its giveaway is intact reality testing: you know the phenomena are not real. Voices, commands, or persecutory beliefs are not HPPD.

- **Cannabis and sleep loss come first.** Stopping every psychedelic and cannabis, and repairing sleep, are the foundation. There is no detox to design.
- **Integration is the main work.** Experiences arrived faster than they could turn into meaning. Using LSD to make sense of LSD is the trap.
- **Check what was on the paper.** Blotter may not be LSD, and NBOMe is the danger.
- **Do not wait for test results to start.** The genome refines the plan (Main Book, Quick-Start Step 3; Supp. Ch. 5, Step 1b).

How chapters are cited. "Main Book" is the Recovery Kernel Main Book (Second Edition, Centurian). "Compendium" is the Complete Protocol Compendium. "Supp. Ch. N" is chapter N of the Supplemental Book. The core chapter is Chapter 26 (How to Recover from LSD). Chapter 27 (Psilocybin) builds on it and is covered in its own guide. Section numbers (§) refer to sections inside those chapters.

> **A note on protocol numbers.** Supplemental Chapter 26 cites Compendium protocols by number, and some numbers do not match the Compendium as printed. It calls Protocol 04 "Dharma Recovery" (printed: Meeting Alternatives), Protocol 03 "exercise and movement" (printed: Sonic Architecture; exercise is Protocol 19), Protocol 22 the nature protocol (printed: The Family Field), Protocol 01 the anxiety and grounding protocol (printed: Emergency Triage), Protocol 05 a stabilization protocol (printed: Digital Detox), Protocol 17 "sleep" (printed: The Nightly Restoration), and Protocol 20 the identity protocol (printed: Mapping the Terrain). It also sends genomic mapping to "Section 15 (Compendium)". This guide cites each protocol by its printed title. If a number and a title disagree, follow the title.
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> For LSD, watch for redosing in the first one to two hours when onset seems slow — that ambiguous window is when a second dose turns a planned experience into an unplanned, much larger one.
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> Redosing is not the only version of this. Watching peers in a treatment setting negotiate a relapse, getting confident advice from someone untrained in your specific situation, or noticing a prescriber treat a prescribed substance more casually than an illicit one can all trigger the same pattern: a felt doubt read as “the plan must be wrong,” answered by abandoning it. See **The Commandeering Map**, a companion to this series, for the fuller pattern, including how it can differ by genetic profile and what helps when practice-based resistance alone is not enough.

2. The route at a glance

Steps 0 and 1 come first. Steps 2 to 4 can run at the same time. Steps 5 to 9 overlap and are the work of the first two years. Step 10 is everything after. "P" means Compendium Protocol; "C" means Centurian Paper.

Step	When	What you do	Turn to
0	Day 0	Triage: a bad trip, NBOMe, psychosis history, medications that prolong LSD.	Supp. Ch. 26 §0, §2 Main Book, Quick-Start Step 1 Compendium P01

Step	When	What you do	Turn to
1	Weeks 1–4	Stop all psychedelics and cannabis. Sleep first. Log any visual phenomena.	Supp. Ch. 26 §3, §7 Compendium P01, P17
2	Weeks 1–4	Read the Main Book in order.	Main Book: Who This Book Is For, Quick-Start, Part One (Ch. 1–5) Supp. Ch. 2, 3
3	Weeks 2–6	Order 30× whole-genome sequencing. HTR2A, COMT, and DRD2 are the priority.	Supp. Ch. 5 Step 1 Supp. Ch. 26 §2 Compendium P06
4	Weeks 2–6	Resolve your profile and your psychosis-risk picture.	Supp. Ch. 5 Steps 2–3, 6 Supp. Ch. 26 §2
5	Day 1 to Month 6	Build the foundation: methylation, sleep, calm, neuroprotection.	Supp. Ch. 26 §4.3, §3.1 Supp. Ch. 5 Phase One Compendium P17, P18
6	Weeks 1–12 if present	HPPD, depersonalization, and the line to psychosis.	Supp. Ch. 26 §4, §8.1
7	Weeks 1–8, then years	The integration sprint, the backlog, and the meaning crisis.	Supp. Ch. 26 §5 Compendium P08
8	From week 2	Treat underlying conditions. The therapeutic LSD question. Medications.	Supp. Ch. 26 §8.2–8.3 Compendium P13
9	Months 2–12+	Build the earned opening: meditation, awe, flow, tradition, sound.	Supp. Ch. 26 §6 C-28; Compendium P19, P29
10	Months 3+, Year 1 to 10	Identity ("what do I do with what it showed me?") and stewardship.	Supp. Ch. 26 §7, §5.4 Supp. Ch. 42, 43, 44 Compendium C-28, P24, P25

3. The route, step by step

Step 0 — Triage (Day 0, before everything)

The Kernel says a bad trip is not usually a medical emergency, and that calling 911 adds strangers, authority, and novelty that can intensify it, so call only for physical danger or a psychiatric break that cannot be talked through. For the person: change to a quiet, dim, familiar space, lie down, reduce sensory input, breathe slowly, and remind yourself it will end. For a sitter: stay calm, since your state is felt acutely; do not talk continuously or interpret the experience ("you're safe, I'm here, this will pass" is enough); anchor to physical reality with a blanket, water, or stepping outside; know the timeline (a typical trip runs 8 to 12 hours, with the peak in hours 2 to 5); and decide when to escalate. A break from reality (not knowing what is real, losing the trip context) is an emergency: tell the physician "this person has taken LSD and may be having a psychotic episode."

Adulterants: NBOMe compounds sold on blotter act at tiny amounts and are far more toxic, with seizures, arrhythmia, overheating, and death documented. The Kernel's tools: Ehrlich reagent, which turns purple with indoles such as LSD, so a sample that does not turn purple is not LSD; and taste, since real LSD is essentially tasteless, so a bitter, chemical, or numbing taste points to NBOMe. Treatment for suspected NBOMe poisoning is emergency care.

> **A caution this guide adds.** A purple Ehrlich result means an indole is present. It does not prove the paper is LSD, because other indoles react too. The taste signal is also not fully reliable. Neither replaces caution or getting the sample properly tested.

Medications: CYP3A4 inhibitors (fluconazole, some antibiotics, grapefruit) can prolong and intensify LSD by slowing clearance, one reason a dose can be unpredictable. Ask your prescriber about anything you take.

Turn to: Supp. Ch. 26 §0 (the bad trip protocol; the trip sitter protocol; the NBOMe adulterant emergency) and §2 (who should not use LSD). Main Book, Quick-Start Boot Sequence, Step 1. Compendium Protocol 01, Emergency Triage, for an acute crisis state.

Step 1 — Stop, stabilize, and sleep (Weeks 1–4)

The Kernel calls this the only guide in the series with no detox protocol, because there is nothing to detox from. The first month is about removing what perpetuates the problem. Stop all LSD and every other 5-HT2A agonist (psilocybin, DMT, mescaline), because the receptor system cannot recover while it is being stimulated. Stop cannabis at the same time: it is the most consistently reported worsener of HPPD and depersonalization, and many people improve markedly within weeks of stopping. Repair sleep, since that is when receptor density recovers, and begin the methylation foundation from day 1. Keep a short record of any visual phenomena so you can see the trajectory.

The aftermath timeline the Kernel gives. Afterglow, days 1 to 3: raised BDNF and looser thinking, the most valuable integration window. Days 1 to 14: 5-HT2A receptors slowly recovering; HPPD, if present, is often most noticeable; sleep is disrupted; the mind keeps working through the experiences. Weeks 2 to 8: receptor sensitivity normalizing, HPPD often easing, integration starting to bring clarity. Months 1 to 6: the receptor system largely recovered and HPPD diminishing for most. Months 6 to 24 and beyond: most HPPD substantially resolved, integration continuing as an ongoing process.

Turn to: Supp. Ch. 26 §3 (the recovery framework; the aftermath timeline) and §7 (the protocol map). Compendium Protocol 01, Emergency Triage, and Protocol 17 (The Nightly Restoration).

Step 2 — Read the Main Book (Weeks 1–4)

Read it in order once you are settled. If you are overwhelmed, the Quick-Start Boot Sequence is designed to be read on its own. Read "Who This Book Is — and Is Not — For" first: it names situations where the supplement protocols need medical modification, including active psychosis, pregnancy, and severe liver disease.

Read in this order: Who This Book Is For → Quick-Start Boot Sequence → Part One: Ch. 1 (Why Willpower Isn't Enough), Ch. 2 (MTHFR), Ch. 3 (COMT; Met/Met is the Kernel's highest LSD psychosis-risk variant), Ch. 4 (CYP450), Ch. 5 (When Systems Collide) → Part Two, the case files (Chapter 6). Ch. 8 (Oxytocin Protocol) is experimental and specialist-only. Ch. 9 (Epigenetic Playground) belongs to Steps 9 and 10. Appendix A and Appendix B are reference.

Then add: Supp. Ch. 2 (Clarity · Restoration · Manning). The Kernel has no LSD case study. Supp. Ch. 27 (Psilocybin), which builds on this chapter, and Supp. Ch. 23 (Ketamine) for the grounding and dissociation side. Supp. Ch. 3 (The Addict Virgin Problem) recalibrates timelines. Supp. Ch. 1 (Why They Left You There) is optional reading for the shame.

Step 3 — Get your DNA (Weeks 2–6)

The Kernel's recommended route is 30× whole-genome sequencing, which returns a VCF file, a one-time asset you keep. A consumer SNP array is an acceptable start. Homocysteine, B12, and RBC folate are functional markers you can recheck quarterly.

LSD targets a different receptor from most substances, so the panel differs. **HTR2A** (the 5-HT2A receptor: high-expression variants mean more intense experiences at the same dose and likely higher HPPD risk; it is not on standard consumer panels, so it needs a pharmacogenomic lab). **COMT** (Met/Met, slow clearance, carries the highest psychosis vulnerability), **DRD2/ANKK1** (A1, fewer D2 receptors; the combination of Met/Met and A1 is the Kernel's highest-risk LSD psychosis profile, and neither alone defines it), **MTHFR**, **SLC6A4** (short/short: higher serotonin sensitivity), **CYP3A4 and CYP2D6** (metabolism and interactions), and **FKBP5/NR3C1** (an exaggerated stress response, which makes surfaced material harder to integrate). Until results arrive: did LSD consistently hit harder than for others at the same amount; do you have any family history of psychosis or bipolar disorder; did visual phenomena persist between uses?

> **Confirm what you are ordering.** Supp. Ch. 5 specifies 30× whole-genome sequencing with VCF output. "WGBS" more commonly names whole-genome bisulfite sequencing, a DNA-methylation assay that is not built to call variants such as MTHFR C677T. Ask the lab for a standard variant file (VCF).

Turn to: Supp. Ch. 5, Step 1. Supp. Ch. 26 §2 (the DNA testing panel for LSD recovery; the psychosis contraindication). Compendium Protocol 06, Phenotype Assessment. Main Book Ch. 2 and Ch. 3 self-assessments.

Step 4 — Resolve your profile (Weeks 2–6)

Write your profile down and carry key results on a card. Trauma history is a specific caution for unsupported LSD use whatever your genes say.

If your result is...	What changes	Source
HTR2A high-expression	More intense experiences at the same dose, deeper default-mode suppression, and likely a higher HPPD risk with frequent use. "I was more sensitive than my friends" is largely this gene.	Supp. Ch. 26 §2

If your result is...	What changes	Source
COMT Met/Met plus DRD2 A1	The Kernel's highest psychosis-risk combination: slow catecholamine clearance meeting fewer D2 receptors, then a surge of prefrontal glutamate. Any psychiatric family history adds to it.	Supp. Ch. 26 §2
COMT Val/Val (Warrior)	Lower psychosis risk, but the experience may have felt less profound at the same dose. The pull may have been more about novelty and intensity.	Supp. Ch. 26 §2
MTHFR variants	A lower baseline serotonin-synthesis capacity, so the system LSD flooded was already thin. 5-MTHF supports serotonin tone and the visual-processing normalization HPPD needs.	Supp. Ch. 26 §2; Main Book Ch. 2
SLC6A4 short/short	More serotonin sensitivity and stronger emotional and social opening, overlapping with MDMA-like effects. Serotonin rebuilding runs alongside receptor recovery.	Supp. Ch. 26 §2
CYP3A4 inhibitors on board	Fluconazole, some antibiotics, and grapefruit can prolong and intensify LSD, which makes dosing unpredictable. Tell any prescriber.	Supp. Ch. 26 §2
FKBP5 / stress-response variants	An exaggerated stress response, especially with trauma history. The material LSD surfaces is harder to integrate, and acute crisis risk is higher.	Supp. Ch. 26 §2

Turn to: Supp. Ch. 5, Steps 2, 3, and 6 (gene systems, combined profiles, profile template). Supp. Ch. 26 §2. Main Book Ch. 5 and Appendix A.

Step 5 — Build the foundation (Day 1 to Month 6)

The Kernel's foundation is simple because there is no dependence. Methylation from day 1: 5-MTHF, methylcobalamin, active B6, and magnesium glycinate. For the perceptual side, the neuroprotective and antioxidant support it names for HPPD: omega-3 DHA, NAC, alpha-lipoic acid, and magnesium. For sleep, the Nightly Restoration protocol, with screens off for two hours before bed and darkness and visual rest, which the Kernel says support receptor recovery. Anxiety management underneath it all: slow extended-exhale breathing daily, magnesium, L-theanine, and exercise. The dose tables are in the chapters and belong with your clinician. Run every addition past a pharmacist and an interaction checker (Drugs.com or Medscape).

Turn to: Supp. Ch. 26 §3.1 (cessation and stabilization), §4.3 (the HPPD management protocol). Supp. Ch. 5, Phase One. Main Book Ch. 2, §2.4–2.5. Compendium Protocol 17 (The Nightly Restoration), Protocol 18 (Eating for Restoration), and Centurian Paper C-32 (The Insomnia Architecture).

Step 6 — HPPD, depersonalization, and the line to psychosis (Weeks 1–12 if present)

HPPD, in the Kernel's terms, is visual phenomena that persist in the sober state: visual snow, afterimages and trails, geometric or fractal imagery (especially in low light or with eyes closed), halos, and intensified colors. What separates it from psychosis is intact reality testing: you know the phenomena are not real objects, and asking "is this real?" is itself evidence you are experiencing an artifact. It does not include voices, command hallucinations, or persecutory beliefs. What separates it from a trip is that it comes without the altered state, ego dissolution, or meaning shift. The Kernel puts prevalence at about 4 to 5 percent of psychedelic users, with risk rising with frequency, high doses, combining psychedelics, cannabis, prior anxiety, and prior head injury. It worsens with anxiety, cannabis, fatigue, fluorescent light, screens, and stress, and improves with time, cessation, sleep, darkness, and rest. Its central claim: for most people, accurate information matters more than medication, because terror of not knowing amplifies the symptoms.

Management, in the Kernel's order: complete psychedelic cessation (non-negotiable); complete cannabis cessation; anxiety management; sleep; and the neuroprotective stack. For severe, impairing HPPD it names short-term clonazepam (with strict limits, because of dependence risk) and lamotrigine, in specialist hands, and advises against SSRIs (which may worsen visual phenomena) and conventional antipsychotics (reported to worsen it in some cases), with mixed results for risperidone, so a psychiatrist who knows HPPD should decide. Depersonalization and derealization (detachment from yourself or a dreamlike, artificial world, with reality testing intact) are driven mainly by anxiety and worsened by cannabis, alcohol, caffeine, and sleep loss. The Kernel's management is grounding, anxiety reduction, stopping all substances, and psychiatric referral for CBT-based DPDR therapy if it is severe and lasts weeks. Any lost reality testing, command hallucinations, persecutory beliefs, or disorganized thinking that grounding does not settle needs urgent psychiatric evaluation.

Turn to: Supp. Ch. 26 §4 (HPPD: what it is and is not; prevalence and risk factors; the management protocol; when medication is needed; depersonalization and derealization) and §8.1 (medical priorities). Compendium Protocol 01, Emergency Triage.

Step 7 — The integration sprint and the meaning crisis (Weeks 1–8, then years)

Integration is turning a raw experience into updated understanding, changed behavior, or processed emotion. The Kernel says it is not having another trip to make sense of the last one, and that the backlog is the arithmetic of frequent use: a trip a week for six months is roughly 24 to 26 experiences arriving faster than they can be metabolized. Its signs: not being able to tell what the trips revealed from what they produced; a lingering altered quality to ordinary perception; anxiety without a clear cause; trouble keeping a consistent worldview; and the sense that something important was met but cannot be reached.

The toolkit: journaling within the first days (describe before interpreting, then reread months later); a psychedelic-informed therapist who neither pathologizes the experience nor treats all of it as revelation; community with others who understand the territory (integration circles, psychedelic support groups); contemplative practice; somatic work (yoga, martial arts, body-based therapy); and creative expression. The meaning crisis: after repeated trips, the ordinary meanings that organized life (career, identity, relationships, belief) can feel insufficient or arbitrary. The Kernel says this is not illness but a genuine philosophical disruption, sometimes the most important work of a life, and that the contemplative traditions have mapped this ground for millennia. LSD gave rapid access without the preparation or the community that make it navigable, and integration is partly finding the map and the people.

Turn to: Supp. Ch. 26 §5 (the integration work: what it is; the backlog; the toolkit; the meaning crisis). Compendium Protocol 08 (Social Environment).

Step 8 — Underlying conditions, the therapeutic LSD question, and medications (from week 2)

The Kernel's medication notes: for anxiety (common with HPPD and depersonalization), buspirone and hydroxyzine; for depression, assess 5-MTHF first, and if an SSRI is needed, use it with HPPD awareness (this is the one place its advice on SSRIs is cautious, not absolute); for sleep, the natural stack and melatonin, and avoid benzodiazepines as sleep aids. Treat any depression, anxiety, or trauma that the trips were addressing directly.

> **Therapeutic LSD: the status is changing.** The Kernel says LSD was studied for alcoholism, anxiety, and depression in the 1950s and 60s and has returned to clinical study. My check of current sources: LSD (as MM120) has FDA Breakthrough designation for generalized anxiety disorder, positive Phase 2b results, and Phase 3 trials for anxiety and depression under way, but I did not find confirmation that it is approved for any use, and it remains Schedule I. Verify current status before relying on any of it.
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> The Kernel's position for someone with LSD use disorder: existing HPPD is an absolute contraindication (more 5-HT2A stimulation will worsen it), a past LSD-triggered psychosis is a contraindication, and the risk of reactivating psychological dependence needs specific assessment. It requires addiction medicine collaboration, full disclosure of history, HPPD clearance, psychosis-risk assessment, and an integration plan beyond standard protocols. It calls this not a categorical exclusion but a categorical requirement for care.

Turn to: Supp. Ch. 26 §8.2 (the therapeutic LSD question) and §8.3 (medications relevant to LSD recovery). Compendium Protocol 13 (The Pharma Trap).

Step 9 — Build the earned opening (Months 2–12+)

The Kernel says this is the most philosophically demanding porting question in the series: how to reach vastness, significance, ego dissolution, and expanded awareness without the drug. Its answer is that every major contemplative tradition was built for exactly this. It maps what LSD gave to a natural route: the loosening of the self (default-mode suppression) to deep meditation and absorption states, built up from 5 to 20 minutes a day over months; the sense of vast significance to deliberate awe (wilderness, night sky, geological scale), which it says measurably reduces self-focus; amplified pattern recognition to creative flow at the edge of competence; the perspective shift to immersive travel and truly unfamiliar frameworks; physiological altered states to breathwork and non-sleep deep rest; and the whole of it to one contemplative tradition practiced consistently, which it says goes deeper than sampling many. Its sound guide: ambient or drone music during integration, silence during meditation (no lyrics), the world's classical traditions for emotional processing, and steady acoustic rhythm at about 60 to 70 beats per minute for grounding when perception is unstable.

> **A caution this guide adds (not in the Kernel).** Hyperventilation-based breathwork can provoke panic, dissociation, or worse in people with a psychosis history, seizure history, heart conditions, or persistent perceptual disturbances or depersonalization. If any of those applies, ask your clinician before trying it, and start with meditation, non-sleep deep rest, and grounding. Sequence matters: be steady in ordinary states first.

Turn to: Supp. Ch. 26 §6 (porting the addiction: the natural access points; the sonic architecture). Centurian Paper C-28 (The Recast). Compendium Protocol 04 (Meeting Alternatives, which the Kernel calls Dharma Recovery), Protocol 19 (The Body in Motion), Protocol 29 (The Peacetime Paradox).

Step 10 — Identity and the long game (Months 3+, Year 1 to Year 10)

The identity question here differs from the usual one: not "who am I without the drug" but "what do I do with what it showed me?" The Kernel says the significance was not an illusion: the brain has its own capacity for significance, and LSD removed a filter that ordinarily screens most of it out. It says the rapid tolerance that makes daily use impossible was, in a sense, the molecule protecting the territory from casual colonization, and that recovery is building the gate: meditation, contemplative tradition, creative work, awe, and sustained attention, slower than a tab and more truly yours. Full Inventory is a structured 180-day plan, and Amends to Self puts the person who lived through it first. Navigation after the first two years shifts from repair to stewardship. Section 4 shows how. Standing tools: Supp. Ch. 44 (The Transplant: redirect the devotion and daily structure the pattern required into a practice that grows). Supp. Ch. 6 (Stay Non-Addicted) and Compendium Protocol 02 (Behavioral Addictions, with its "Mask Change" caution on addiction transfer). Compendium Protocol 13 (The Pharma Trap). Supp. Ch. 38. Supp. Ch. 5, Step 6 (a weekly AI check-in profile, a reasoning tool and never a provider).

Turn to: Supp. Ch. 26 §5.4, §7 (identity work; the long game). Supp. Ch. 42 (Full Inventory). Supp. Ch. 43 (Amends to Self). Centurian Paper C-28 (The Recast). Compendium Protocol 24 (Returning to Work), Protocol 25 (The Open Door), Protocol 22 (The Family Field), Protocol 16 (The Isolation Spiral). Supp. Ch. 51 (Family & Support Network Guide): give it to the people who love you. Resources the Kernel names: hppd-online.com and the Zendo Project (zendoproject.org).

4. How navigation changes at Years 3, 5, and 10

Shading shows how much attention each track needs. Darkest is primary focus, then active, then maintenance. White cells with gray text are standing safeguards: low effort, never dropped. Numbers in brackets refer to the shifts listed below the table. The Kernel's LSD timeline ends at about two years, so later years are projection.

Track	Months 0–24 (foundation)	Year 3 (consolidate)	Year 5 (build out)	Year 10 (steward)
Safety and medical	Psychosis screen; HPPD watch	Mood plan; therapy decision [1]	Mood plan, clinician-led	Psychosis rule holds for life [7]
Biology and genome	HTR2A, COMT; DRD2, 5-MTHF	Retest labs; step stack to upkeep [2]	Prescriber card: HTR2A, CYP3A4	Re-check with new meds and age
Cues and rituals	Supply, scene, circles reviewed	Sober days feel fine	Triggers shift: meaning, loss [4]	Same plan, rehearsed
Integration work	Integration first; journal, therapist	Backlog cleared; ongoing practice [3]	Reflective practice weekly	Reflection stays part of life
Sleep, calm, perception	Sleep first; no cannabis	Perception steady; sleep restored	Anxiety plan, clinician-led	Stress plan, sleep habits
Natural access practice	Daily sit; awe; flow, creative	Daily practice; tradition chosen	Practice deepens; retreat, teacher [5]	Practice as a way of life
Meaning and Manning	Meaning crisis: hold, don't solve	Identity beyond the trips	Manning: guide, integration peer [6]	Mentor or run a group

The seven shifts

1. **Year 3, the mood decision and any therapeutic decision.** If depression or anxiety outlasted early recovery, treat it directly, with 5-MTHF first and an HPPD-aware psychiatrist if a drug is needed (Supp. Ch. 26 §8.3). If you consider therapeutic LSD, the Kernel's conditions apply: HPPD clearance, psychosis-risk assessment, disclosure, and an integration plan (Supp. Ch. 26 §8.2), and the trial picture has been changing, so check it fresh.
2. **Year 3, the stack moves from building to upkeep.** The Kernel says the 5-HT2A system is largely recovered within months and most HPPD substantially resolved by 6 to 24 months (Supp. Ch. 26 §3.1). Retest labs (Supp. Ch. 5 Step 1a) and step down toward maintenance. The Trinity chapter says supplements are taken until stable, then tapered and resumed if the system destabilizes; Main Book Ch. 2 treats MTHFR support as maintenance, not cure. Step down to maintenance, not to zero.
3. **Year 3, the backlog is cleared and integration becomes a practice.** The Kernel says integration is not a phase that ends: the first year is the most

intensive, then it is ongoing reflection (Supp. Ch. 26 §7). By year 3 the backlog should be metabolized and reflective life should be ordinary.

4. **Year 5, triggers shift to meaning and loss.** The Kernel says the pull is existential, the sober world feeling narrow, not physical craving (Supp. Ch. 26 §1.3). As cues fade, a major loss, a life transition, or a return of that restlessness is the exposure. Keep the contemplative practice and Protocol 21 ready. This shift is extrapolation.
5. **Year 5, the practice deepens.** The Kernel says reliable access to deeper meditative states takes consistent daily practice over months to years, and that one tradition practiced consistently goes deeper than sampling (Supp. Ch. 26 §6, §7). By year 5 a teacher, community, or retreat is a natural step. Follow this guide's caution about breathwork if any risk factor applies.
6. **Year 5, Manning.** This is the Trinity's third stage (Supp. Ch. 2). This is extrapolation: integration circles, peer support, and guiding others who are in the same territory, with lived knowledge of the opening and the aftermath.
7. **Year 10, the psychosis rule holds for life.** The Kernel calls the contraindication absolute regardless of dose, experience, or setting, and existing HPPD a bar to therapeutic use (Supp. Ch. 26 §2, §8.2). Any future decision about a psychedelic of any kind stays with specialists and depends on that history.

What is sourced and what is extrapolated. *Shifts 3, 5, and 7 rest directly on Kernel text. Shifts 1 and 2 apply Kernel rules at a timing chosen for this guide. Shifts 4 and 6 are extrapolations. The Kernel's detailed LSD timeline ends at about two years, and its WHEN Correlator puts deep-root reversal at 2 to 5 or more years for heavy long-term use.*

5. What outcome to expect

The short version

The Kernel has no LSD case study and gives no 12-month percentages, so this section is qualitative and does not make up numbers. If you do the route above, with the psychosis screen first, all psychedelics and cannabis stopped, sleep repaired, HPPD understood, the backlog worked through with support, and the earned opening built, this is what the Kernel supports:

- **Weeks 2 to 8:** HPPD, if present, often eases, sleep steadies, and integration starts to bring clarity.
- **Months 1 to 6:** the 5-HT2A system is largely recovered, HPPD is diminishing for most, and the meaning the trips opened begins to metabolize into life.
- **Months 6 to 24 and beyond:** most HPPD has substantially resolved, integration continues as a lifelong practice, and the practices you built are, in the Kernel's words, "not substitutes" but "the real thing."
- **By years 3 to 5 the work is maintenance and building. By year 10 you are a steward,** carrying a small set of standing safeguards.

The Kernel does not promise zero risk, and it does not claim all HPPD resolves: a small minority stay clinically significant. If psychosis was triggered, psychiatric care is the primary path, and this guide only supports it.

Milestones, in order

Milestone	When	Expected outcome	Source	Basis
Afterglow	Days 1–3	BDNF-enhanced plasticity and looser thinking: the best window for journaling and integration.	Supp. Ch. 26 §1.4	Kernel projection
Early aftermath	Days 1–14	Receptors slowly recovering. HPPD, if present, often most noticeable. Sleep disrupted. Stop cannabis. Begin journaling.	Supp. Ch. 26 §3.1	Kernel projection
Integration and easing	Weeks 2–8	Receptor sensitivity normalizing. HPPD often reducing. Integration begins to produce clarity.	Supp. Ch. 26 §3.1	Kernel projection
Receptor recovery	Months 1–6	5-HT2A system largely recovered. HPPD diminishing for most. Meaning beginning to metabolize into life.	Supp. Ch. 26 §3.1	Kernel projection
HPPD resolution	Months 6–24+	Most HPPD substantially resolved. A small minority persist at clinically significant levels.	Supp. Ch. 26 §§3.1, 4.2	Kernel projection
Ongoing integration	Months 6–24+	Material slowly metabolized into life wisdom. The meaning question may stay active for years.	Supp. Ch. 26 §3.1	Kernel projection
Deep-root reversal	2–5+ years	Prefrontal recovery and epigenetic reversal continue. Some changes may be partial.	Supp. Ch. 36	Kernel projection
Steward phase	Years 3–10	Repair tracks at maintenance. Contemplative practice. Service. Standing safeguards.	Section 4 of this guide	Extrapolated

The Kernel's 12-month numbers: none for LSD

The Kernel has no LSD case study and gives no LSD-specific projection, so there is no 12-month table here, and this guide will not make one up. The nearest profiles in Supplemental Chapter 2 concern other substances: Case 09 (ketamine, an NMDA and trauma profile) and Case 06 (MDMA, a serotonin profile). Neither is a prediction for LSD. What the Kernel does offer is the aftermath timeline above.

What changes the outcome

- **Ignoring psychosis history,** or continuing after a psychotic-like episode.
- **Continuing cannabis.** The Kernel calls it the most reliable HPPD and depersonalization aggravator.
- **Using again to make sense of the last trip.** The Kernel names this the trap that produces accumulation.
- **Skipping integration** and treating trips as finished events. The backlog is the main problem.
- **Treating psychosis or lost reality testing as "HPPD."** It needs urgent evaluation.

- **Sleep loss, anxiety, caffeine, and late-night screens,** which worsen HPPD and depersonalization.
- **SSRI or antipsychotic changes without HPPD awareness,** since the Kernel says either may worsen visual phenomena.
- **Untested blotter.** Not everything sold as LSD is LSD.
- **A lapse.** The Kernel treats it as information, not judgment (Protocol 21). Ask what state was underneath it, keep a sober sitter, and get help for any frightening experience.

How to read the evidence behind the outcomes

The Main Book marks claims with an Evidence Tier: Established, Probable, Emerging, Author/System Experience, and Controversial or Mixed. This guide's reading: the psychosis contraindication, the adulterant danger of NBOMe, and rapid tolerance are well established. HPPD is a recognized condition, but the Kernel's prevalence figure (4 to 5 percent), its medication notes (clonazepam, lamotrigine), and its advice to avoid SSRIs and conventional antipsychotics rest on limited case-level evidence, so treat them as questions for a specialist. The Kernel's statement that awe measurably reduces self-focus is supported by research on awe but is modest in size. The natural-access comparisons to meditative states, the supplement stack, the sound guide, and the years 3 to 10 trajectory sit lower on that scale, so bring them to your clinician as questions, not as facts.

Take these to your clinician

- An honest account of your use: how often, what amounts, how you sourced it, any other psychedelics or cannabis, and any frightening experiences or adverse events.
- Any personal or family history of psychosis, schizophrenia, or bipolar disorder, and any time you lost track of what was real, so a psychiatric evaluation can be arranged if needed.
- Any persisting visual phenomena or feelings of detachment, described specifically, and whether you know they are not real.
- Every medication and supplement you take, especially antibiotics, antifungals, antidepressants, and antipsychotics, and your HTR2A, COMT, DRD2, and MTHFR results if you have them.
- What the trips were treating (depression, trauma, anxiety, meaning), and whether a psychedelic-informed therapist can help with integration.